Complete Summary

GUIDELINE TITLE

Caregiving strategies for older adults with delirium, dementia and depression.

BIBLIOGRAPHIC SOURCE(S)

Registered Nurses Association of Ontario (RNAO). Caregiving strategies for older adults with delirium, dementia and depression. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2004 Jun. 181 p. [247 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Dementia, delirium, and depression

GUIDELINE CATEGORY

Education
Management
Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Nursing

INTENDED USERS

Advanced Practice Nurses
Nurses

GUIDELINE OBJECTIVE(S)

- To present nursing best practice guidelines for caregiving strategies for older adults with delirium, dementia, and depression
- To recommend care strategies to assist Registered Nurses (RNs) and Registered Practical Nurses (RPNs) who are working in diverse settings in acute, long-term, and community care

TARGET POPULATION

Older adults (65 years or older) with delirium, dementia and/or depression

INTERVENTIONS AND PRACTICES CONSIDERED

1. Screen for changes in cognition, function, behavior and/or mood
2. Assess differences between delirium, dementia, and depression (Diagnostic and Statistical Manual [DSM IV-R], Resident Assessment Instrument [RAI], and Minimum Data Set [MDS])
3. Identify, recognize, and prevent contributing factors to dementia, delirium, and depression (i.e., environment, medication, pain)
4. Develop/facilitate partnerships with family members and caregivers; provide education as needed
5. Assess patient ability to provide personal care and treatment and financial decisions
6. Develop multi-component care strategies (nonpharmacological and pharmacological interventions)
7. Provide ongoing assessments to identify status changes
8. Avoid physical and chemical restraints as first line care strategies
9. Provide nursing education strategies directed at the competencies required for practice
10. Provide organization and policy strategies directed at practice settings and the environment in order to facilitate nurses´ practice

MAJOR OUTCOMES CONSIDERED

- Morbidity
- Mortality
- Quality of life
- Length of stay in acute care

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A database search for existing guidelines was conducted by a university health sciences library. An initial search of the MEDLINE, Embase, and CINAHL databases for guidelines and articles published from January 1, 1995, to December 2002, was conducted using the following search terms: "delirium management", "dementia management", "depression management", "geriatrics", "practice guideline(s)", "clinical practice guideline(s)", "standards", "consensus statement(s)", "consensus", "evidence-based guidelines", and "best practice guidelines".

One individual searched an established list of Web sites for content related to the topic area. This list of sites, reviewed and updated in October 2002, was compiled based on existing knowledge of evidence-based practice Web sites, known guideline developers, and recommendations from the literature. Presence or absence of guidelines was noted for each site searched, as well as date searched. The Web sites at times did not house a guideline but directed to another Web site or source for guideline retrieval. Guidelines were either downloaded, if full versions were available, or were ordered by phone/e-mail.

A Web site search for existing guidelines on delirium, dementia, and depression was conducted via the search engine "Google," using the search terms identified above. One individual conducted this search, noting the search term results, the Web sites reviewed, date, and a summary of findings. The search results were further critiqued by a second individual who identified guidelines and literature not previously retrieved.

Additionally, panel members were already in possession of a few of the identified guidelines. In some instances, a guideline was identified by panel members and not found through the previous search strategies. These were guidelines that were developed by local groups or specific professional associations. The results of this strategy revealed 21 guidelines and numerous articles related to delirium, dementia, and depression.

The final step in determining whether clinical practice guidelines would be critically appraised was to have two individuals screen the guidelines based on the specific inclusion criteria. These criteria were determined by panel consensus:

- Guideline was in English, international in scope.
- Guideline was dated no earlier than 1996.
- Guideline was strictly about the topic areas (delirium, dementia, depression).
- Guideline was evidence-based (e.g. contained references, description of evidence, sources of evidence).
- Guideline was available and accessible for retrieval.

Twelve guidelines were deemed suitable for critical review using the Appraisal of Guidelines for Research and Evaluation instrument.

NUMBER OF SOURCE DOCUMENTS

Following the appraisal process, the guideline development panel identified eight guidelines to develop the recommendations cited in the guideline.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Level of Evidence

Ia - Evidence obtained from meta-analysis or systematic review of randomized controlled trials

Ib - Evidence obtained from at least one randomized controlled trial

IIa - Evidence obtained from at least one well-designed controlled study without randomization

IIb - Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization

III - Evidence obtained from well-designed nonexperimental descriptive studies, such as comparative studies, correlation studies, and case studies

IV - Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

In January of 2003, a panel of nurses and researchers with expertise in practice, education, and research related to gerontology and geriatric mental health care was convened under the auspices of the Registered Nurses Association of Ontario

(RNAO). At the onset, the panel discussed and came to a consensus on the scope of the best practice guideline.

Following the extraction of identified recommendations and content from eight guidelines, the panel underwent a process of review, discussion, and consensus on the key evidence-based assessment criteria.

The panel members divided into subgroups to undergo specific activities using the short-listed guidelines, other literature, and additional resources for the purpose of drafting recommendations for nursing interventions. This process yielded a draft set of recommendations. The panel members as a whole reviewed the recommendations, discussed gaps and available evidence, and came to consensus on a draft guideline.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The development process yielded an initial set of recommendations. The panel members as a whole reviewed the recommendations, discussed gaps and available evidence, and came to consensus on a draft guideline.

This draft was submitted to a set of external stakeholders for review and feedback. Stakeholders represented various health care disciplines as well as professional associations. External stakeholders were provided with specific questions for comment, as well as the opportunity to give overall feedback and general impressions. The results were compiled and reviewed by the development panel. Discussion and consensus resulted in revisions to the draft document prior to publication and evaluation.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The levels of evidence supporting the recommendations (Ia, Ib, IIa, IIb, III, IV) are defined at the end of the "Major Recommendations" field.

	Recommendation	Level of Evidence
Practice Recommendations	1.1 Nurses should maintain a high index of suspicion for the prevention, early recognition, and urgent treatment of delirium to support positive outcomes.	IIa
	1.2 Nurses should use the diagnostic criteria from the Diagnostic and Statistical Manual (DSM) IV-R to assess for delirium, and document mental status observations of hypoactive and hyperactive delirium.	IV
	1.3 Nurses should initiate standardized screening methods to identify risk factors for delirium on initial and ongoing assessments.	IIa
	1.4 Nurses have a role in prevention of delirium and should target prevention efforts to the client's individual risk factors.	Ib
	1.5 In order to target the individual root causes of delirium, nurses working with other disciplines must select and record multicomponent care strategies and implement them simultaneously to prevent delirium. 1.5.1 Consultation/Referral Nurses should initiate prompt consultation to specialized services. 1.5.2 Physiological Stability/Reversible Causes Nurses are responsible for assessing, interpreting, managing, documenting, and communicating the physiological status of their client on an ongoing basis. 1.5.3 Pharmacological Nurses need to maintain awareness of the effect of pharmacological interventions, carefully review the older adults´ medication profiles, and report medications that may contribute to potential delirium.	III

	Recommendation	Level of Evidence
	1.5.4 Environmental Nurses need to identify, reduce, or eliminate environmental factors that may contribute to delirium. 1.5.5 Education Nurses should maintain current knowledge of delirium and provide delirium education to the older adult and family. 1.5.6 Communication/Emotional Support Nurses need to establish and maintain a therapeutic supportive relationship with older adults based on the individual´s social and psychological aspects 1.5.7 Behavioural Interventions Nurses are responsible for the prevention, identification and implementation of delirium care approaches to minimize disturbing behaviour and provide a safe environment. Further, it is recommended that restraints not be used.	
	1.6 Nurses must monitor, evaluate, and modify the multi-component intervention strategies on an ongoing basis to address the fluctuating course associated with delirium.	IIb
Practice Recommendations for Dementia	2.1 Nurses should maintain a high index of suspicion for the early symptoms of dementia to initiate appropriate assessments and facilitate individualized care.	IIa
	2.2 Nurses should have knowledge of the most common presenting symptoms of Alzheimer Disease, Vascular Dementia, Frontotemporal Lobe Dementia, and Lewy Body Dementia, and be aware that there are mixed dementias.	IV
	2.3 Nurses should contribute to comprehensive	IIa

	Recommendation	Level of Evidence
	standardized assessments to rule out or support the identification and monitoring of dementia based on their ongoing observations and expressed concerns from the client, family, and interdisciplinary team.	
	2.4 Nurses should create partnerships with family members or significant others in the care of clients. This is true for clients who live in either the community or in health care facilities.	III
	2.5 Nurses should know their clients, recognize their retained abilities, understand the impact of the environment, and relate effectively when tailoring and implementing their caregiving strategies.	III
	2.6 Nurses caring for clients with dementia should be knowledgeable about pain assessment and management in this population to promote physical and emotional well-being.	IV
	2.7 Nurses caring for clients with dementia should be knowledgeable about nonpharmacological interventions for managing behaviour to promote physical and psychological well-being.	III
	2.8 Nurses caring for clients with dementia should be knowledgeable about pharmacological interventions and should advocate for medications that have fewer side effects.	Ia
Practice Recommendations for Depression	3.1 Nurses should maintain a high index of suspicion for early recognition/early treatment of depression in order to facilitate support and individualized care.	IV
	3.2 Nurses should use the diagnostic criteria from the Diagnostic and Statistical Manual (DSM) IV-R to assess for depression.	IV
	3.3 Nurses should use standardized assessment tools to identify the predisposing and precipitating risk factors associated with depression.	IV

	Recommendation	Level of Evidence
	3.4 Nurses must initiate prompt attention for clients exhibiting suicidal ideation or intent to harm others.	IV
	3.5 Nurses must be aware of multi-component care strategies for depression. 3.5.1 Nonpharmacological interventions 3.5.2 Pharmacological caregiving strategies	Ib
	3.6 Nurses need to facilitate creative client/family/community partnerships to ensure quality care that is individualized for the older client with depression.	IV
	3.7 Nurses should monitor the older adult for re-occurrence of depression for 6 months to 2 years in the early stages of recovery and ongoing for those with chronic depression.	Ib
Practice Recommendations for Delirium, Dementia, and Depression	4.1 In consultation/collaboration with the interdisciplinary team: • Nurses should determine if a client is capable of personal care, treatment, and financial decisions. • If client is incapable, nurses should approach substitute decision makers regarding care issues. • Nurses should determine whom the client has appointed as Power of Attorney (POA) for personal care and finances, and whenever possible include the Power of Attorney along with the client in decision-making, consent, and care planning. • If there is no Power of Attorney, nurses should encourage and facilitate the process for older adults to appoint Power of Attorney and to have discussions about end of life treatment and wishes while mentally capable.	IV
	4.2 In care settings where Resident Assessment	III

	Recommendation	Level of Evidence
	Instrument (RAI) and Minimum Data Set (MDS) instruments are mandated assessment tools, nurses should utilize the MDS data to assist with assessment for delirium, dementia and depression.	
	4.3 Nurses should avoid physical and chemical restraints as first line care strategies for older adults with delirium, dementia, and depression.	III
Education Recommendation	5.1 All entry-level nursing programs should include specialized content about the older adult such as normal aging, involvement of client and family throughout the process of nursing care, diseases of old age, assessment and management of delirium, dementia, and depression, communication techniques, and appropriate nursing interventions.	IV
Organization & Policy Recommendations	6.1 Organizations should consider integration of a variety of professional development opportunities to support nurses in effectively developing knowledge and skills to provide care for older adults with delirium, dementia, and depression.	IV
	6.2 Health care agencies should implement a model of care that promotes consistency of the nurse/client relationship.	IIb
	6.3 Agencies should ensure that nurses´ workloads are maintained at levels conducive to care of persons with delirium, dementia, and depression.	IV
	6.4 Staffing decisions must consider client acuity, complexity level, and the availability of expert resources.	III
	6.5 Organizations must consider the nurses´ well-being as vital to provide care to persons with delirium, dementia and depression.	III
	6.6 Health care agencies should ensure the coordination of care through the appropriate processes to transfer information (e.g.,	IV

	Recommendation	Level of Evidence
	appropriate referrals, communication, documentation, policies that support formal methods of information transfer, and networking between health care providers).	
	6.7 (Delirium) Brief screening questions for delirium should be incorporated into nursing histories and/or client contact documents with opportunity to implement care strategies.	IV
	6.8 (Delirium) Organizations should consider delirium programs that contain screening for early recognition and multi-component interventions for treatment of clients with, but not limited to, hip fractures, post-operation surgery, and those with complex medical conditions.	IV
	6.9 (Depression) Caregiving activities for the older adult presenting with depression and/or suicidal ideation should encompass primary, secondary and tertiary prevention practices.	IV
	6.10 Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes: • An assessment of organizational readiness and barriers to education • Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process • Dedication of a qualified individual to provide the support needed for the education and implementation process • Ongoing opportunities for discussion and education to reinforce the importance of best practices • Opportunities for reflection on personal and organizational experience in implementing	IV

	Recommendation	Level of Evidence
	guidelines In this regard, Registered Nurses Association of Ontario (RNAO) (through a panel of nurses, researchers and administrators) has developed the Toolkit: Implementation of Clinical Practice Guidelines, based on available evidence, theoretical perspectives and consensus. The RNAO strongly recommends the use of this Toolkit for guiding the implementation of the best practice guideline on Caregiving Strategies for Older Adults with Delirium, Dementia and Depression.	

Definitions:

Level of Evidence

Ia - Evidence obtained from meta-analysis or systematic review of randomized controlled trials

Ib - Evidence obtained from at least one randomized controlled trial

IIa - Evidence obtained from at least one well-designed controlled study without randomization

IIb - Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization

III - Evidence obtained from well-designed nonexperimental descriptive studies, such as comparative studies, correlation studies, and case studies

IV - Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence is provided for each recommendation (see "Major recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Nurses who have acquired the knowledge and skills to properly assess and initiate treatment of delirium, dementia, and depression, will help prevent illness, decrease morbidity and mortality, enhance health, and improve the quality of life of the older adults.
- Early recognition/treatment is associated with decreased morbidity, mortality, length of stay in acute care, and may assist in preventing irreversible cognitive impairment and institutionalization.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The document needs to be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client. Guidelines should not be applied in a "cookbook" fashion but used as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.
- These best practice guidelines are related only to nursing practice and are not intended to take into account fiscal efficiencies. These guidelines are not binding for nurses and their use should be flexible to accommodate client/family wishes and local circumstances. They neither constitute a liability nor discharge from liability. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the Registered Nurses Association of Ontario (RNAO) give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work. Any reference throughout the document to specific pharmaceutical products as examples does not imply endorsement of any of these products.
- It is acknowledged that the individual competencies of nurses varies between nurses and across categories of nursing professionals (registered nurses [RNs] and registered practical nurses [RPNs]) and are based on knowledge, skills, attitudes, critical analysis, and decision-making which are enhanced over time by experience and education. It is expected that individual nurses will perform only those aspects of care for which they have received appropriate education and experience. Since care strategies for delirium, dementia and depression are based on accurate screening assessment of these conditions, the development panel for this guideline strongly recommends the implementation of this guideline in conjunction with the RNAO (2003) Best Practice Guideline entitled Screening for Delirium, Dementia and Depression in Older Adults.

- It is expected that nurses, both RNs and RPNs, will seek appropriate consultation in instances where the client´s care needs surpass the individual´s ability to act independently. It is acknowledged that effective health care depends on a coordinated interdisciplinary approach incorporating ongoing communication between health professionals and clients, ever mindful of the personal preferences and unique needs of each individual client.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Best practice guidelines can only be successfully implemented if there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. The Registered Nurses Association of Ontario (RNAO), through a panel of nurses, researchers, and administrators, has developed the Toolkit: Implementation of Clinical Practice Guidelines based on available evidence, theoretical perspectives, and consensus. The Toolkit is recommended for guiding the implementation of any clinical practice guideline in a health care organization.

The Toolkit provides step-by-step directions to individuals and groups involved in planning, coordinating, and facilitating guideline implementation. Specifically, the Toolkit addresses the following key steps:

1. Identifying a well-developed, evidence-based clinical practice guideline
2. Identification, assessment, and engagement of stakeholders
3. Assessment of environmental readiness for guideline implementation
4. Identifying and planning evidence-based implementation strategies
5. Planning and implementing evaluation
6. Identifying and securing required resources for implementation

Implementing practice guidelines that result in successful practice changes and positive clinical impact is a complex undertaking. The Toolkit is one key resource for managing this process.

Evaluation and Monitoring

Organizations implementing the recommendations in this nursing best practice guideline are advised to consider how the implementation and its impact will be monitored and evaluated. A table found in the original guideline document, based on the framework outlined in the RNAO Toolkit: Implementation of clinical practice guidelines (2002), illustrates some suggested indicators for monitoring and evaluation.

IMPLEMENTATION TOOLS

Tool Kits

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Registered Nurses Association of Ontario (RNAO). Caregiving strategies for older adults with delirium, dementia and depression. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2004 Jun. 181 p. [247 references]

ADAPTATION

The panel, following the appraisal process, identified the following guidelines, and related updates, to adapt and modify recommendations:

- Alexopoulos, G., Silver, J., Kahn, D., Frances, A., & Carpenter, D. (1998). The expert consensus guideline series: Treatment of Agitation in Older Persons with Dementia. Expert Consensus Guideline Series [On-line]. Available: http://www.psychguides.com/gl-treatment_of_agitation_in_dementia.html
- American Psychiatric Association. (APA) (2000). Practice guideline for the treatment of patients with major depression. American Psychiatric Association [On-line]. Available: www.psych.org/psych_pract/treatg/pg/Depression2e.book.cfm
- American Psychiatric Association. (APA) (1999). Practice guideline for the treatment of patients with delirium. American Psychiatric Association [On-line]. Available: www.psych.org/psych_pract/treatg/pg/pg_delirium.cfm
- American Psychiatric Association. (APA) (1997). Practice guideline for the treatment of patients with Alzheimer disease and other dementias of late-life. American Journal of Psychiatry, 144, 1-51.
- Centre for Health Services Research & Department of Primary Care, University of Newcastle upon Tyne (1997). The primary care management of dementia. National Electronic Library for Health [On-line]. Available: www.ncl.ac.uk/pahs/research/services/publications/guide/dementia.pdf
- Ellis, P. M. & Smith, D. A. R. (2002). Treating depression: The beyondblue guidelines for treating depression in primary care. The Medical Journal of Australia, 176 (10 Suppl), S77-S83.

- National Advisory Committee on Health and Disability (1996). Guidelines for the treatment and management of depression by primary healthcare professionals. New Zealand: New Zealand Guidelines Group.
- Scottish Intercollegiate Guidelines Network (SIGN)(1998). Intervention in the management of behavioural and psychological aspects of dementia. Scottish Intercollegiate Guidelines Network [On-line]. Available: www.sign.ac.uk/pdf/sign22.pdf

DATE RELEASED

2004 Jun

GUIDELINE DEVELOPER(S)

Registered Nurses Association of Ontario - Professional Association

SOURCE(S) OF FUNDING

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GUIDELINE COMMITTEE

Not stated

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Declarations of interest and confidentiality were made by all members of the guideline development panel. Further details are available from the Registered Nurses Association of Ontario (RNAO).

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Registered Nurses Association of Ontario (RNAO) Web site.

Print copies: Available from the Registered Nurses Association of Ontario (RNAO), Nursing Best Practice Guidelines Project, 158 Pearl Street, Toronto, Ontario M5H 1L3.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Summary of recommendations. Caregiving strategies for older adults with delirium, dementia and depression. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2004 Jun. 5 p.

  Electronic copies: Available in Portable Document Format (PDF) from the Registered Association of Ontario (RNAO) Web site.

- Toolkit: implementation of clinical practice guidelines. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2002 Mar. 88 p.

  Electronic copies: Available in Portable Document Format (PDF) from the Registered Nurses Association of Ontario (RNAO) Web site.

Print copies: Available from the Registered Nurses Association of Ontario (RNAO), Nursing Best Practice Guidelines Project, 158 Pearl Street, Toronto, Ontario M5H 1L3.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on November 3, 2004. The information was verified by the guideline developer on November 23, 2004.

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